MEDICAID PRESCRIPTION REFORM

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Alabama's Medicaid Drug Program

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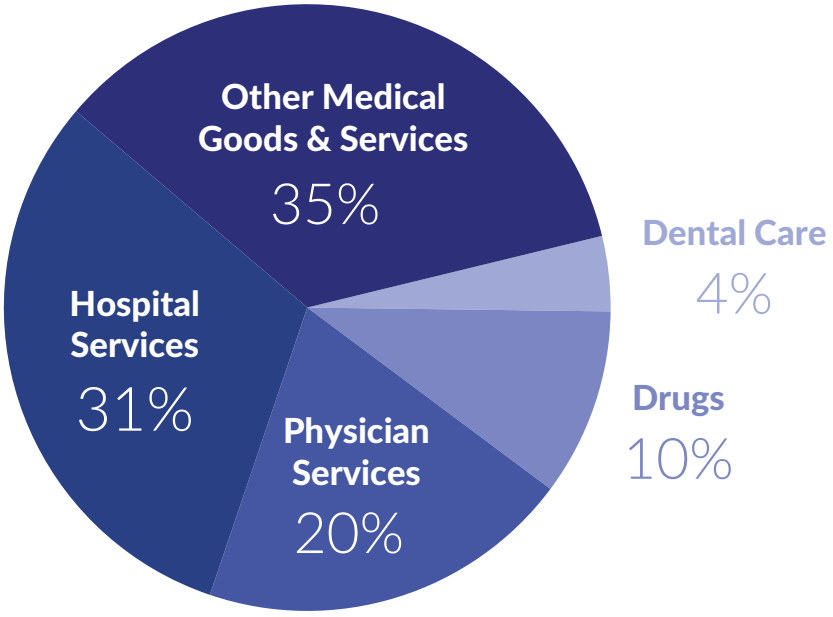
One million Alabamans are enrolled in Medicaid, a joint federal-state program that provides medical care to nearly 70 million low-income individuals nationwide.[1] Medicaid is one of the two primary expenditures in most state budgets, and Alabama is no exception. Medicaid consumes over one-third of the General Fund, and costs state and federal taxpayers nearly $6 billion annually — about one-tenth of which participants spend on drugs and drug therapies.

Medicaid officials anticipate enrollment will increase as a result of the Patient Protection and Affordable Care Act. In addition, Medicaid spending on drug therapies will rise as the prevalence of costly specialty drugs increases. Thus, slowing the growth of Medicaid drug spending is a fiscal imperative for Alabama's state budget.

The Importance of Medicaid Drug Benefits

Drug benefits are an important component of Medicaid. Drug therapy is not only convenient, it is also the most efficient way to treat many health conditions. Moreover, drugs are a relative bargain compared to other medical expenditures. Americans spend twice as much on doctors and about three times as much on hospital care as on drug therapies.[2] [See Figure I.] However, the cost of drug therapies is rising. Specialty drugs are supplanting the tablets, capsules and elixirs Americans have come to expect from their doctors. And as this occurs, drug spending is expected to grow at an increasing rate.

Figure 1: Drug Spending as a Proportion of All Health Care Expenditutre (2012)



Source: "National Health Expenditures by Type of Sercive and Source of Funds, CY 1960-2012," Centers for Medicare & Medicaid Services, U.s. Department of Health and Human Services, page last modified January 7, 2013. Available at: http://www.cmsgov/Research-Statistics-Data-and-Systems/Systems/Statistics-Trends-and-Reports/NationalHeathExpendData/Downloads/NHE201.zip

[1] KAISER FAMILY FOUNDATION, Total Monthly Medicaid and CHIP Enrollment (Dec. 2014), http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/ (last visited Apr. 15, 2015).
[2] CENTERS FOR MEDICARE AND MEDICAID SERVICES, National Health Expenditure Projections 2012-2022, Table 1, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf (last visited Apr. 15, 2015).

Medicaid drug programs work differently in each state, depending on whether state officials or private health plans administer drug benefits. Regardless how the program is administered, Medicaid enrollees purchase most of their drugs at local pharmacies that are reimbursed for the cost of each prescription filled, plus a dispensing fee.

Alabama's Medicaid drug program is entirely "fee-for-services" (FFS). This means the state administers pharmaceutical drug benefits separately from health benefits (called a "carve out"), and reimburses pharmacies for each prescription filled (called FFS). Rather than negotiating fees, Alabama reimburses pharmacies for drugs based on a benchmark price known as "average acquisition cost." Because this methodology reduces drugstores' profit margins when serving Medicaid customers, the state pays an overly generous dispensing fee to boost drugstores' profit margins. The Alabama Medicaid drug program does not maintain exclusive networks; virtually any drugstore is allowed to fill Medicaid enrollees' prescriptions. Alabama passed a law to implement a Medicaid preferred drug list in 2003, but for the most part, Alabama Medicaid does not actively manage drug benefits; it merely reimburses claims for Medicaid beneficiaries. By contrast, managed drug plans typically negotiate drug dispensing fees with pharmacies, create cost-effective formularies and assemble preferred networks of qualified specialty drug providers and competitive pharmacies.

How to Improve Medicaid Drug Programs

The Menges Group, a consultancy that evaluates state Medicaid programs with an emphasis on special needs populations, identified a few of the ways state Medicaid drug programs waste money.[3] For example:

- Drug prices often differ unnecessarily from one pharmacy to the next.
- State Medicaid programs arbitrarily pay much higher dispensing fees than would occur in a competitive market.
- State Medicaid fee-for-service drug programs use low-cost, generic drugs less than efficiently-managed programs.
- Moreover, the number of redundant and unnecessary prescriptions per Medicaid enrollee is often higher for state-managed fee for service drug programs.

With these problems in mind, Alabama Governor Robert Bentley established the Medicaid Pharmacy Study Commission in June 2013 to examine the potential for better Medicaid pharmacy management.[4] The commission found the potential savings from a well-managed Medicaid drug program was substantial. The commission's report — released in December 2013 — outlined several options to boost the efficiency of

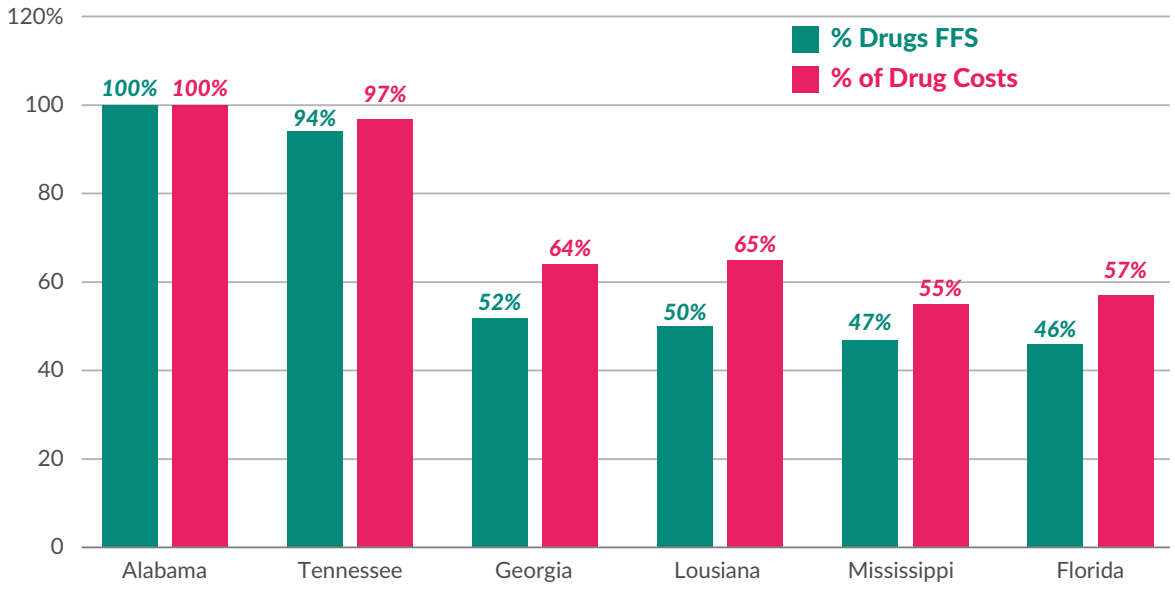
[3] JOEL MENGES, MENGES GROUP, MEDICAID PHARMACY SAVINGS OPPORTUNITIES: NATIONAL AND STATE-SPECIFIC ESTIMATES (May 1, 2013), available at www.themengesgroup.com/upload_file/final_medicaid_savings_report_menges_group_may_2013.pdf.
[4] Brandon Moseley, Bentley Establishes Alabama Medicaid Pharmacy Study Commission, ALABAMA POLITICAL REPORTER (June 2013), www.alreporter.com/archives/archive-2013/2013-june/4718-bentley-establishes-alabama-medicaid-pharmacy-study-commission.html.

Alabama's Medicaid drug program.[5] The commission's findings were consistent with other recent analyses by both the Menges Group and the Lewin Group, another consultancy.[6] [More on this later.]

Limitations of Fee-for-Service Medicaid Drug Programs

Virtually all state Medicaid programs distribute some drugs on a fee-for-service basis, but Alabama is among the states that distribute *all* Medicaid drugs this way.[7] [See Figure II.] Prior to the Patient Protection and Affordable Care Act (ACA), mandatory drug rebates were only available to state-administered fee-for-service drug programs. States depended on these mandatory rebates to offset a portion of the cost. However, the ACA changed this practice by also allowing rebates for drugs administered through Medicaid managed care plans and managed drug plans. This shift has led to increased use of managed drug benefits across the country. Since 2011, the value of prescription drugs dispensed through Medicaid managed care has more than doubled nationwide.[8]

Figure 2: Percent of Drugs Dispensed Fee for Service



Source: 2014 Drug Utilization Review Annual Reports, Medicaid Drug Programs Data & Resources, Medicaid.gov. http://www.medicaid.gov/Medicade-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Programs-Data-and-Resources.html

[5] DONALD E. WILLIAMSON, ALABAMA MEDICAID PHARMACY STUDY COMMISSION, REPORT OF THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION (Dec. 26, 2013), available at www.medicaid.alabama.gov/documents/2.0_Newsroom/2.2_Boards_Committees/2.2.2_Pharmacy_Study_Commission/2.2.2_AL_Medicaid_Pharmacy%20Commission_Report_12-30-13.pdf.

[6] JOEL MENGES ET AL., LEWIN GROUP, PROJECTED IMPACTS OF ADOPTING A PHARMACY CARVE-IN APPROACH WITHIN MEDICAID CAPITATION PROGRAMS (Jan. 2011), www.mhpa.org/_upload/mhpapaperpharmacycarve-in.pdf. See also JOEL MENGES ET AL., LEWIN GROUP, POTENTIAL FEDERAL AND STATE-BY-STATE SAVINGS IF MEDICAID PHARMACY PROGRAMS WERE OPTIMALLY MANAGED (Feb. 2011), www.lewin.com/~/media/Lewin/Site_Sections/Publications/MedicaidPharmacySavingsReport_Rev.pdf.

[7] JOEL MENGES, MENGES GROUP, MEDICAID PHARMACY SAVINGS OPPORTUNITIES: NATIONAL AND STATE-SPECIFIC ESTIMATES (May 2013), www.pcmanet.org/images/stories/uploads/2013/final%20medicaid%20savings%20report%20menges%20group%20may%202013.pdf.

[8] MURRAY AITKEN ET AL., SHIFT FROM FEE-FOR-SERVICE TO MANAGED MEDICAID: WHAT IS THE IMPACT ON PATIENT CARE? IMS INSTITUTE FOR HEALTHCARE INFOR¬MATICS (Apr. 2013), www.imshealth.com/deployedfiles/ims/Global/Content/Insights/IMS%20Institute%20for%20Healthcare%20Informatics/2012%20Medicaid%20Report/IIHI_Medicaid_Report_4_13.pdf.

Most Americans walk out of their physicians' offices with a prescription in hand. According to government statistics, about three-quarters of physician visits result in prescription drug therapy.[9] Drug therapies often mitigate the need for more expensive surgical treatments. Failing to take a beneficial drug can also result in unnecessary hospitalizations. Under managed care, Medicaid pays a set fee per enrollee to provide care, which makes them liable for the cost of nondrug therapies. It stands to reason that managed care plans should also be responsible for drug therapy, given that drugs are often a less costly substitute for surgery or other treatments. Thus, the health plans that provide medical care to Medicaid enrollees are the logical entities to manage drug benefits.

Problem: Care Coordination

States that administer their own Medicaid drug programs often ignore the benefits of drug therapy coordination and management. This policy can harm patients.[10] For instance, the state of New Hampshire implemented a prescription limit on psychiatric drugs in 1990, leading to increased use of emergency mental health services and increased hospitalization of people with schizophrenia. The additional medical costs associated with poor medication management was 17 times greater than the savings from limiting prescriptions.[11] By contrast, an analysis of Medicaid managed pharmacy benefits in a number of states by IMS Health found utilization rates for generic antipsychotics and diabetes medications tended to be higher under managed care than fee for service. According to IMS, use of generic versions of antipsychotic medications average 3 percent to 14 percent higher than in fee-for-service Medicaid. Drug utilization for diabetes was also higher in some states studied.[12]

Problem: Specialty Drug Management

Another consideration is the growing use of specialty drugs. Specialty drugs require a level of experience and expertise unmanaged drug benefits simply cannot support. Specialty pharmacies are often referred to as "high touch" pharmacy services. They serve patients who need specialty drugs and biological agents that require extensive monitoring, risk evaluation, mitigation strategies for side effects and diagnostic support by a physician. Indeed, the Food and Drug Administration sometimes requires care coordination and close monitoring of a specialty drug therapy as a condition of approval for a new drug. Though specialty drugs represent only 0.5 percent of prescriptions under Alabama Medicaid, these drugs account for one-quarter of drug spending.[13] A recent example of a costly medication that is affecting Medicaid programs is the Hepatitis C drug, Sovaldi. With a retail price of $1,000 per pill, a course of treatment is approximately $84,000. Thus, costly therapies like this should be carefully managed to hold down costs.

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[9] U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, National Ambulatory Medical Care Survey: 2010 Summary Tables, www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf (last viewed Apr. 15, 2015).

[10] For example, see Gerome Wilson et al. Medicaid Prescription Drug Access Restrictions: Exploring the Effect on Pa¬tient Persistence with Hypertension Medications, 11 AMERICAN JOURNAL OF MANAGED CARE, SP27, SP27-SP34 (2005), www.ajmc.com/publications/issue/2005/2005-01-vol11-n1SP/Jan05-1984pSP027-SP03/.

[11] Stephen B. Soumerai et al., Effects of a Limit on Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia, 331 New England Journal of Medicine 650, 650-655 (1994). See also Chris Koyanagi et al., Medicaid Policies to Contain Psychiatric Drug Costs, 24 Health Affairs 536, 536-544 (2005), available at http://content.healthaffairs.org/content/24/2/536.full.

[12] AITKEN ET AL., supra note 8.

[13] Alabama Prescription Services, The Alabama Solution, Presentation to the Alabama Medicaid Pharmacy Study Commission (Oct. 24, 2013), available at www.medicaid.alabama.gov/documents/2.0_Newsroom/2.2_Boards_Committees/2.2.2_Pharmacy_Study_Commission/2.2.2_APS_Presentation_10-24-13.pdf.

Competition Lowers Costs

- An estimated **220 million** Americans belong to a health plan that provides medications through a managed drug plan — coordinating the participation of drug companies, PBMs and pharmacies to provide benefits to consumers.
- The process is highly competitive: PBMs compete for the right to manage health plan members' drug benefits; drugstores compete to attract drug plan members filling a prescription; and drug makers compete to ensure their drugs are in enrollees' prescription pill bottles.
- The process is often antagonistic — involving intense negotiation, competitive bidding and price competition.
- The degree to which drug benefits are managed efficiently has a significant effect on consumers' (and taxpayers') costs.

Problem: Efficiency

Moving away from Medicaid fee-for-service drug programs also increases efficiency. The Lewin Group found managed drug plans are more cost-effective than plans that administer drugs separately from health benefits.[14] Indeed, a Lewin analysis found integrating health plan and drug benefits in 13 states that currently carve out drug benefits would collectively save states and the federal government nearly $11.1 billion over a decade.

Private-sector health plans, Medicare Part D drug plans and many state Medicaid managed care plans contract with pharmacy benefit managers (PBMs), private firms that act as third-party prescription drug plan administrators. Private health plans and PBMs use a variety of techniques to control drug costs, including: preferred-drug lists, formularies, mandatory use of mail-order drug suppliers, negotiated volume discounts with drug makers and exclusive contracts with pharmacy network providers. Drug plan managers negotiate drug prices and rebates with drug manufacturers, process claims and reimburse for drugs dispensed. They also negotiate dispensing fees.

Medicaid Managed Care

Like most other states, Alabama is forging ahead with plans to move Medicaid enrollees into managed care plans. In doing so, the state should change its policy of carving out drug benefits.[15]Alabama Medicaid could benefit from contracting with professional PBMs to administer drug benefits for those in managed care plans. The governor's commission study found that states with lower per unit drug costs were typically delivered through managed care. Every penny reduction in drug costs per unit would save state taxpayers approximately $5 million.[16]

[14]MENGES ET AL., supra note 6.
[15]AITKEN ET AL., supra note 8.
[16]WILLIAMSON, supra note 5.

For instance, if Alabama lowered its per unit drug costs to the same level as Georgia, the state could save about $90 million.[17] Nationally, the number of prescriptions per Medicaid enrollee is generally higher among enrollees in fee-for-service Medicaid programs compared to managed care; thus, Alabama could save even more taxpayer dollars if efficiently managed drug benefits reduced the number of unnecessary or fraudulent prescriptions filled.

Effect on Stakeholders

Many pharmacists are small business owners. Community pharmacies often serve Medicaid beneficiaries and depend on state Medicaid reimbursements and dispensing fees for a portion of their livelihood. Independent pharmacies are an important part of Alabama's infrastructure serving Medicaid enrollees — especially in rural areas where there are few alternatives. Thus, state legislators should take them into account when formulating a plan to extract cost-savings from the Medicaid drug program.

However, this advice should not encourage unnecessary protections that diminish the cost-saving benefits of reform. For example, trade associations for independent pharmacies often advocate for laws that discourage cost-efficient, mail-order drug programs commonly found under managed care. These groups sometimes lobby for dispensing fees set by the legislature rather than have those fees determined by competitive bidding and negotiation. Many large retail pharmacies now dispense and sell a month's supply of generic drugs for $4. It doesn't make sense that the standard Medicaid dispensing fee is $10.64 (plus the cost of ingredients), when there are pharmacies willing to perform the same service for one-third the price. On the other hand, community drugstores in rural areas — where competition is sparse — might negotiate higher dispensing fees than independent drugstores located in urban areas where there are numerous competitors. Whatever the dispensing fee, it should be determined in a competitive marketplace.

Community pharmacists also lobby lawmakers to prohibit drug plan managers from limiting the number of pharmacies in a network, a tactic PBMs sometimes use to negotiate lower drug prices (and dispensing fees) from pharmacies. For example, Alabama requires that any willing pharmacy be allowed to participate in the Medicaid drug program rather than allowing health plans to develop networks of preferred pharmacies willing to provide lower prices. Any willing pharmacy laws not only reduce the ability of drug plan managers to negotiate lower prices, they also facilitate waste and fraud by requiring Medicaid to reimburse numerous pharmacies. This type of legislation makes it more difficult to detect billing fraud by unscrupulous pharmacy operators. Indeed, the Federal Trade Commission has argued on numerous occasions that these laws increase prices for consumers and plan sponsors.[18]

[17] Id.

[18] For example, see ANDREW I. GAVIL ET AL., FEDERAL TRADE COMMISSION, U.S. DEPARTMENT OF COMMERCE, Contract Year 2015 Policy and Technical Changes to the Medicare Ad¬vantage and the Medicare Prescription Drug Benefit Programs (Mar. 7, 2014), www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-centers-medicare-medicaid-services-regarding-proposed-rule/140310cmscomment.pdf.

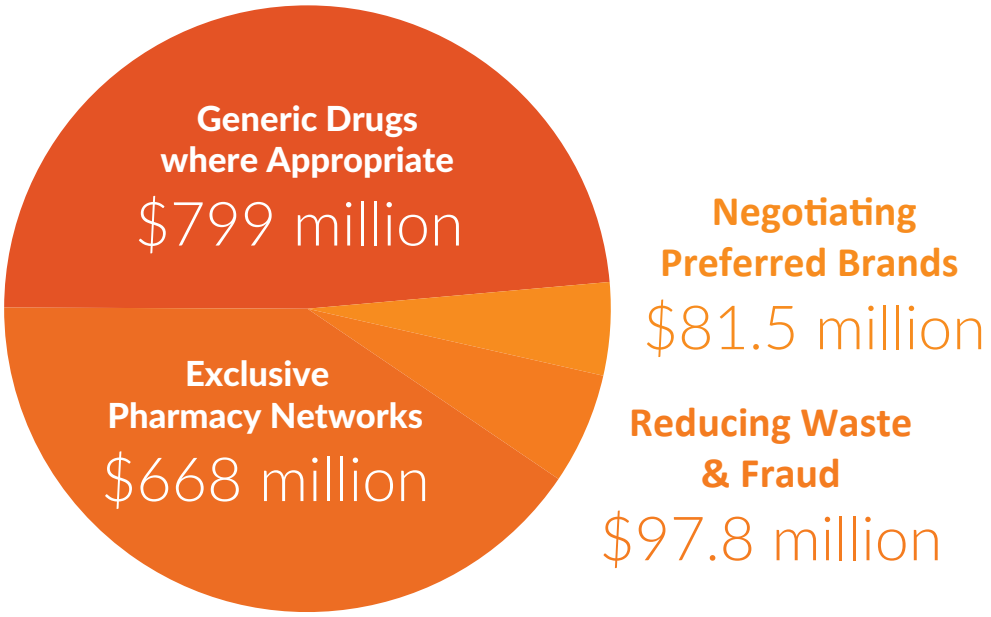
Analysis by consulting actuary Optumas, hired by Alabama's Medicaid agency, found independent pharmacies would suffer only modest financial impact from reform. Drug plan managers exclude few independent pharmacies from Medicare Part D pharmacy networks. The same firms would be expected to compete to administer Alabama Medicaid drug benefits. Thus, network participation would likely be similar under Medicaid.

Potential Savings. According to a 2013 study by the Menges Group, better management of Medicaid prescription drug benefits could save Alabama Medicaid $1.6 billion over 10 years ($1.1 billion in lower federal spending and $513 million less in state spending).19 Specifically, as Figure III shows:

- About half (49 percent) of the savings would come from use of generic drugs where appropriate.
- More than one-third (41 percent) of the savings would come from negotiating steep discounts with exclusive (limited) networks.
- Use of preferred brands and better management of waste and fraud would save 11 percent.

Alabama Medicaid's generic fill rate has risen since Menges' analysis. However, the analysis did not estimate savings from paying market-based, competitive dispensing fees. Alabama pays pharmacies $10.64 to dispense a prescription, whereas the national average for private Medicare Part D plans is one-fifth as much — about $2.00. Paying market-based dispensing fees would likely further reduce costs — possibly lowering dispensing fees by 60 percent or more.

Figure 1: Drug Spending as a Proportion of All Health Care Expenditutre (2012)



Note: Potential savings for market-based dispensing fees was not analyzed but could likely be lowered through negotiation.

[19]MENGES, supra note 7.

The Alabama Medicaid Pharmacy Study Commission looked at three options. These included:

- Purchasing and Network Management Cooperative
- Pharmacy Benefit Management
- Preferred Pharmacy Network

A *Purchasing and Network Management Cooperative* would purportedly improve care management, specifically specialty drug management. This option is significant because costly specialty drugs are a growing trend. A consultant for the state Medicaid agency estimated the annual savings for this approach at $9 million to $18 million.

Pharmacy Benefit Managers are firms that private health plans, many state Medicaid agencies and Medicare Part D drug plans use to administer drug benefits. After adjusting for the loss of a provider tax, this approach is estimated to save the state $13 million to $35 million each year.

A *Preferred Pharmacy Network* is an exclusive network of pharmacies. In a sample network limited to Walmart pharmacies, the savings to the state would be $19 million to $30 million annually.

How do these proposals differ? First, note that they are not mutually exclusive. For instance, a professional pharmacy benefit manager may seek to establish a preferred pharmacy network. A PBM would also want to carefully manage specialty drugs. And a preferred pharmacy network would still benefit from the services of a professionally managed PBM.

Recommendations

1 Allow health plans to manage drug benefits for those already in managed care.

2 Transition to professional pharmacy benefit managers for special needs and disabled individuals to better control the cost of specialty drugs.

3 Reform the remaining fee-for-service drug programs to require market-based dispensing fees.

4 Repeal any willing pharmacy regulations designed to prevent preferred pharmacy networks and mail-order drug delivery.

Conclusion

Alabama legislators have a decision to make. It is in Alabama taxpayers' interest to provide drugs to Medicaid enrollees at the lowest possible cost to the state. The governor's commission found that employing the services of pharmacy benefit managers would lower costs. Two other options explored also found cost savings. These additional options — including hiring a purchasing and network management cooperative and utilizing a preferred pharmacy network — are by no means mutually exclusive. Indeed, a pharmacy benefit manager would like use purchasing and network management and a preferred provider network.

Lawmakers will undoubtedly come under political pressure to protect local providers from the type of competition that could save Alabama taxpayers money. A better way is to foster competition among pharmacies competing for the right to serve Alabama's Medicaid enrollees.

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