Congress Whets Its Carving Knife: Deep Cuts for Medicaid Drug Reimbursement

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Congress will almost certainly take a scalpel to Medicaid payments to pharmacies for prescription drugs. “The system is broken, and it needs to be fixed,” says Representative Joe Barton (R-Texas), chairman of the House Energy and Commerce Committee, one of the two House committees with jurisdiction.

Mike Leavitt, the new Secretary of the Department of Health and Human Services, fueled more talk about upcoming changes to Medicaid when he said, during his confirmation hearings in January, that the program is “inefficient” and in need of better management. That prescription could easily be applied to Medicaid payments for outpatient pharmaceuticals, which have ballooned.

Between fiscal years 1997 and 2002, Medicaid’s expenditures for prescription drugs in the fee-for-service part of the program increased by an average annual rate of 18%, growing from $10.2 billion to $23.4 billion. Drug spending by Medicaid increased at an annual average rate of 19% from fiscal years 2000 to 2002. Medicaid’s spending as a whole grew by 12% each year during that period.

That same trend afflicted Medicare, leading Congress to establish the new average sales price (ASP) method of calculating Medicaid reimbursement to physicians who purchase drugs for administration in their offices. The savings to Medicare from the ASP method are projected at $15 billion over 10 years.

The new method replaces a calculation that was dependent upon the average wholesale price (AWP), which most states have used when determining how much to pay a pharmacy for a drug purchased by a Medicaid recipient. The problem: the AWP is not an authentic price; moreover, this price is often set up to advance a scam.

In reality, drug manufacturers make up an AWP, almost out of thin air. This price is reported to Medicaid, and it is the price upon which reimbursement to the pharmacy is established. However, the manufacturer actually charges the pharmacy a significantly lower price, leading to a spread, which constitutes an extra profit for pharmacies and an extra unnecessary payment for Medicaid.

George Reeb, assistant inspector general for the Centers for Medicare & Medicaid Services (CMS) audits at the U.S. Department of Health and Human Services’ (DHHS) Office of Inspector General (OIG), says that pharmacy acquisition costs for brand-name drugs in 1999 averaged 21.8% below the AWP; for generic drugs, they averaged 65.9% below the AWP.

A study by the Congressional Budget Office in December 2004 detailed the recent expansion of the spread, also referred to as the “markup.” Between 1997 and 2002, the average markup increased by nearly 60% (approximately 9.7% per year), rising from $8.70 to $13.80 per prescription. Much of the increase in the average markup was attributable to the use of relatively new generic drugs. For generic drugs that came on the market between 1997 and 2002, Medicaid reimbursed pharmacies an average of $46 per prescription in 2002, but only about $14 of this amount went for the purchase of the drug itself; the remainder ($32 per prescription) went to pharmacies and wholesalers.

Although the Medicaid program saved money overall from the substitution of newer generic drugs for brand-name drugs, its spending was not reduced to nearly the extent it might have been if the markups on newer generic drugs had more closely approximated those for older generics and brand-name drugs.

A host of other problems besides the AWP are bedeviling Medicaid reimbursement. States can establish whatever reimbursement rate they want for individual drugs—and those rates vary widely. Mr. Reeb has stated that Medicaid could have cut its spending by more than half in 1999 if all states had paid the same price as the lowest-paying state for the same drug.

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A host of other problems besides the AWP are bedeviling Medicaid reimbursement. States can establish whatever reimbursement rate they want for an individual drug—and those rates vary widely. Mr. Reeb has stated that Medicaid could have cut its spending by more than half in 1999 if all states had paid the same price as the lowest-paying state for just nine of 28 drugs. These savings estimates are derived from only 28 National Drug Codes that were randomly selected from 600 codes for which the Medicaid outlays were substantial. Medicaid covers more than 50,000 National Drug Codes, implying a potential for even greater program savings.

That is a staggering projection, and it helps explain why pharmacies may bleed heavily after Congress gets through slashing the Medicaid drug reimbursement.